cocktail hours at geriatric nursing homes resulted in improved morale, and surprisingly, a bettering of cognitive skills.

Serious work is being done by individual investigators. Foremost is Marc A. Schuckit, formerly director of the Alcoholism and Drug Abuse Institute of the University of Washington, and now continuing his in-depth research of the problems of elderly alcoholics at the Veterans Administration Medical Center in San Diego. There is an ever-increasing effort by church workers to deal with these problems, as exemplified by the pioneering work of Father James E. Royce of Seattle University.

It is now evident to me that I as a practicing physician have given too little thought to the enigma of elderly alcoholics. I am sure most of my colleagues will confess to a similar lack of interest or understanding. How many of us have given thought to the drug interactions between alcohol and the medications we prescribe or the over-the-counter items our patients may be using? Haven't most of us taken the easy course of dismissing elderly alcoholics as a minor social problem rather than a medical responsibility?

Alcoholism in the elderly is difficult of diagnosis, often being overlooked as frailty or senility. It may escape detection because it is deliberately hidden or because we are not on the alert for it. But once detected and diagnosed its treatment is highly successful.

Part of the remedy is society's responsibility. As we strive to rid ourselves of racism and sexism, let us also eliminate ageism. For our part as physicians let us sharpen our skills in geriatric care. Medical schools need to teach courses in geriatrics as well as in pediatrics.

And, yes, maybe more public forums on "Alcohol and the Elderly" will help bring the problem out of the closet.

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Inoculation by Bronchoscopy

TO THE EDITOR: I would like to add an interesting case report to the cases of serious infectious complications after flexible fiberoptic bronchoscopy, as reported by Drs. Aelony and Finegold in the October 1979 issue of the journal.

In 1974 I saw in consultation a 20-year-old man who had been involved in an automobile accident in Honolulu in 1972. He had suffered fractured femurs and fracture of the large toe, right foot, and fractured ribs. As a result of the fractured ribs, a pneumothorax on the left developed.

He had been admitted to an Armed Forces Hospital in Honolulu, where a tracheotomy was done and chest tubes were placed; bronchoscopy was carried out via a rigid bronchoscope for the pneumothorax and for control of secretions. Ultimately his condition improved and he was discharged.

Seven months after discharge he had been readmitted with a pulmonary infiltration. Bronchoscopy again was done and organisms grew Pseudomonas pseudomallei, which led to the diagnosis of acute melioidosis. This organism is found classically in Southeast Asia, but is not found in the Hawaiian Islands.

At the time there were other patients with this organism in the hospital and they had previously contracted the infection in Southeast Asia, and there was evidence that in another patient in the hospital at this time with this infection, bronchoscopy had been carried out with the same scope.

It can be assumed, therefore, that this represents a case of transmission of an unusual infection via bronschoscopy somewhat different than the more acute infections as defined by Drs. Aelony and Finegold.

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Gonococcal Pharyngeal Infections

TO THE EDITOR: Regarding the letter of Michael Sands in the October issue on "Treatment of Gonococcal Pharyngeal Infections in Men," it was not stated whether the population surveyed was heterosexual or homosexual. Perhaps this information is not known.

It is my understanding that gonococcal pharyngitis in men occurs primarily in the homosexual population. I would appreciate his comment.

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Dr. Sands Replies

TO THE EDITOR: The population in the study group were all homosexual men.

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